**STATE OF MICHIGAN**
**IN THE SUPREME COURT**

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

v

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance company,

Defendant-Appellant.

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw County Circuit Court
No. 13-020416-NF

/

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# BRIEF OF AMICUS CURIAE AUTO CLUB INSURANCE ASSOCIATION IN SUPPORT OF APPLICATION FOR LEAVE TO APPEAL

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## STATEMENT OF INTEREST

Amicus Curiae, AUTO CLUB INSURANCE ASSOCIATION ("ACIA"), is a reciprocal automobile inter-insurance exchange organized under MCL 500.7200 *et seq*, to sell motor vehicle insurance in Michigan. ACIA issues approximately 20% of the motor vehicle policies in this State, making it one of the largest single automobile insurers.

The instant case is one of hundreds and hundreds filed by healthcare providers against no-fault insurers. ACIA and other AAA Michigan insurers have been among the biggest targets of such suits.

The practical problems of tracking and litigating these spurious cases has been immensely complicated by the Court of Appeals' decision in the instant case. The process of settling a claim with one's own insured now requires notification of any provider who has ever submitted a bill. Even then, a hearing is required to "apportion" the settlement.

As one of the largest automobile insurers in the State, ACIA has a self-evident interest in seeing the avalanche of satellite litigation stopped, and some order restored to the no-fault system.

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## STATEMENT OF QUESTIONS PRESENTED

I. DOES THE NO-FAULT ACT CONFER ANY RIGHTS UPON HEALTHCARE PROVIDERS?

Amicus Curiae, AUTO CLUB INSURANCE ASSOCIATION, contends the answer should be, "No".

II. EVEN IF HEALTHCARE PROVIDERS HAVE A PROCEDURAL RIGHT TO SUE, ARE THEIR SUBSTANTIVE RIGHTS TOTALLY SUBSERVIENT TO THOSE OF THE INJURED PERSON, WHO MAY WAIVE OR SETTLE THEM AS HE SEES FIT?

Amicus Curiae, AUTO CLUB INSURANCE ASSOCIATION, contends the answer should be, "Yes".

## REASONS FOR GRANTING LEAVE TO APPEAL

The past several years have seen an explosion of cases filed against no-fault insurers by healthcare providers. The decision in the instant case has added an element of chaos to an already burdensome situation by materially complicating the process of settling no-fault claims with the insured persons.

This Court has before it two cases which, taken together, afford a signal opportunity to remedy the situation. One is the instant case. The other is *Chiropractors Rehabilitation Group, PC v State Farm Mutual Automobile Ins Co*, Supreme Court No. 152807/*Elite Health Centers, Inc v State Farm Mutual Automobile Ins Co*, Supreme Court No. 152808. For the following reasons, this Court should seize the opportunity.

### The Scope of the Problem: Volume of Cases

Recent years have seen an explosion of satellite litigation involving healthcare providers suing no-fault insurers to recover for services rendered to insureds who are injured in auto accidents. In one instance, a single motor vehicle accident in which two persons were injured spawned seven separate suits in four different courts.[1] Globally, the picture is even more bleak. **As of September 2013, two insurers, STATE FARM and AAA Michigan, had more than 1,000 pending cases filed against them directly by healthcare providers -- in addition to suits by the insureds**. (Appendices F, G).

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[1] *Russell & Young v State Farm*, Wayne County Circuit Court No. 11-009075-NF; *Russell & Young v State Farm*, Wayne County Circuit Court No. 11-010633-NF; *Maple Millennium Medical Center, PLLC v State Farm*, 46th District Court No. 11-3761-GC; *Maple Millennium Medical Center, PLLC v State Farm*, 46th District Court No. 11-3744-GC; *Summit Medical Group, PLLC v State Farm*, 50th District Court No. 12-157483-GC; *Summit Medical Group, PLLC v State Farm*, Wayne County Circuit Court No. 12-008722-NF; *Daudi, PC, Back-In-Line v State Farm*, 31st District Court No. 12-51424-GC.

Other data provide a snapshot over time of the torrent of these cases. Rather than rely on anecdotal perception, FOIA requests were sent out in April 2015 to many different district courts throughout southeast Michigan as well as a few circuit courts. While the circuit court numbers are proving difficult to obtain, five separate district courts have responded. These numbers do not reflect the hundreds of no-fault lawsuits in which medical providers intervene on a daily basis:

- Affiliated Diagnostics of Oakland, LLC: 2012 to the present: **674 lawsuits** filed (44th and 46th District Courts only)
- Mendelson Orthopedics, P.C.: 2011 to the present: **320 lawsuits** filed (37th District Court only)
- Summit Medical Group, LLC: 2011 to the present: **259 lawsuits** filed (19th District Court only)
- Infinite Strategic Innovations, Inc.: 2013 to the present: **190 lawsuits** filed (19th District Court only)
- Northland Radiology, Inc.: 2014 to the present: **101 lawsuits** filed (46th District Court only)
- Doctors Medical, LLC: 2013 to the present: **74 lawsuits** filed (19th District Court only)
- Silver Pine Imaging, LLC: 2013 to present: **57 lawsuits filed** (15th District Court only)

(Appendix D).

The result has been a multiplication of the transactional costs to insurers and, ultimately, to the motoring public, as well as an increased burden on the time and resources of the courts of this State.

**Complicating the Problem: Inability To Settle**

As if the burden of tracking and litigating spurious claims filed in different courts were not burdensome enough, the Court of Appeals in the instant case added to the problem. Until recently, a no-fault insurer could confidently settle a case with an insured, and be secure in the knowledge that it was the responsibility of the insured's attorney to see that all claims were included in the settlement. *Clark v Al-Amin*, 309 Mich App 387, 390-91; 872 NW2d 730 (2015).

Through a misreading of MCL 500.3112 (which is demonstrated in Issue I., *infra*), the panel in the instant case held that an insurer cannot settle with its insured alone. Rather, it must include in the process any provider which has submitted a bill, and obtain an "apportionment order" from the circuit court. The circuit courts are now inundated with requests for "apportionment hearings". In one pending case, the no-fault insurer must notify 85 separate providers of the apportionment hearing. (Appendix E).

The source of both of the foregoing problems is a chronic misreading of §3112. For reasons set forth below, §3112 does not confer any rights on a healthcare provider, much less an entitlement to abort a settlement between a no-fault insurer and its insured. The issues presented are, without question, of major significance to the jurisprudence of this State, MCR 7.302(B)(3). In addition, the decision of the Court of Appeals in the instant case directly conflicts with published authority holding that an injured person may waive or settle the provider's claim against the no-fault insurer. *Miller v Citizens Ins Co*, 490 Mich 905; 804 NW2d 740 (2011); *Moody v Home Owners Ins Co*, 304 Mich App 415, 442-43; 849 NW2d 31 (2014), MCR 7.302(B)(5).

This Court should grant leave to appeal in the instant case.

## INTRODUCTION

In the instant case, the Court of Appeals tells us that a no-fault insurer can no longer settle its insured's claim without notifying all medical providers who have ever submitted a bill for payment.

The holding and result in the instant case are the result of a decade of the Court of Appeals' overenthusiastic embrace of *stare decisis*, at the expense of any thoughtful legal analysis of the language of the statute it purported to enforce. In doing so, it has ignored a fundamental limitation on that doctrine:

> "*Stare decisis* must be rejected where independent legal analysis leads to a conclusion that is contradictory to earlier decisions."

*In the Matter of Henry*, 38 BR 24, 26 (ND Ga 1983).

> "**Old cases, no matter how numerous, should not stand, if**, under modern and different conditions, **they cannot withstand the impact of critical analysis**. The doctrine of **stare decisis should never be used as a substitute for such critical analysis**. If an old rule cannot withstand such analysis it should be overruled."

*Amaya v Home Ice, Fuel & Supply Co*, 59 Cal 2d 295; 379 P2d 513, 526 (1963) (Peters, J., dissenting) (emphasis added), *rev'd*, *Dillon v Legg*, 68 Cal 2d 728; 441 P2d 912, 925 (1968).[2]

This Court, too, has condemned the unthinking invocation of stare decisis:

> "Admitting that *Chrysler*'s minority was and is right, the **Chief Justice interposes the perennially debated rule of *stare decisis* -- in its most extreme and wholly discredited form of judicial self-stultification -- as a pronounced bar to correction by this Court of its so confessed error**. In plain bread and butter words, the asserted position amounts to no more than this: Because, in 1941, an irreparable injustice was committed by the Court against a multitude of Chrysler employees -- the legislature since having remained disinterested in correction by its hand of our grievous misinterpretation at that time --, the Court in 1959 must equally oppress thousands more of correspondingly situated Ford

[2]The *Dillon* court adopted the position of the dissenter quoted in the text.

> employees; indeed, must continue such oppression in future like cases until the legislature directs otherwise. **Thus rudely denuded, we behold the altiloquent notion that *stare decisis* renders judicial error -- of statutory interpretation -- frozen-final so far as the errant appellate court is concerned. Needless to say, we reject both the notion and its disreputable postulates**."

*Park v Appeal Board of Michigan Employment Security Comm'n*, 355 Mich 103, 142-43; 94 NW2d 407, 425 (1959), *overruling Chrysler Corp v Smith*, 297 Mich 438; 298 NW 87 (1941) (emphasis added).

The instant case is the end product of years of the Court of Appeals' parroting prior decisions. What is even more egregious is that the seminal case in the *stare decisis* conga line -- *Lakeland Neurocare Centers v State Farm*, 250 Mich App 35; 645 NW2d 59 (2002) -- is cited for **a proposition that was not even litigated in that case**.

The Court of Appeals decision in the instant case is a corollary of a demonstrably erroneous premise. Its reasoning was as follows:

(1) Section 3112 of the No-Fault Act confers on healthcare providers independent standing to pursue a claim directly against a no-fault insurer to recover money owed to it by the injured person.

(2) That right to benefits is created by the injured person's right to benefits.

(3) However, the insured's relinquishment of his rights does not affect the rights of a healthcare provider who has submitted a bill to the insurer.

That has given rise to a rash of so-called "apportionment hearings", which are now filed every time a no-fault insurer attempts to settle a claim.

The problem originates with the premise, i.e., that the No-Fault Act confers **any** rights on a healthcare provider. That premise is, in turn, based on the false assumption that the phrase "to or for the benefit of the injured person" bestows on the entity whom the insurer might pay "for

the benefit of the injured person" a **right** to recover from the insurer. Indeed, the existence of such a right is a necessary predicate to the Court of Appeals' holding that Plaintiff had a "claim" of which STATE FARM had notice.

For reasons more fully explicated below: (1) The plain English meaning of the quoted phrase is that it bestows an entitlement on "the injured person", and on no one else; and (2) The last four sentences of §3112 apply **only to survivor's loss benefits**.

If we accept the contrary premise, it quite plausibly leads to the result in the instant case, with considerable systemic collateral damage along the way in the form of hundreds and hundreds of additional lawsuits routinely filed by healthcare providers. It is, therefore, necessary for this Court to address that premise in order to finally resolve the issue presented.

It is past time for this Court to intercede and to restore some sanity to the no-fault system.[3]

[3]This Court has declined to do so at least twice. *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 497 Mich 1029; 863 NW2d 54 (2015); *Detroit Medical Center v State Farm Mutual Automobile Ins Co*, 495 Mich 917; 840 NW2d 350 (2013).

## I. THE NO-FAULT ACT DOES NOT CONFER ANY RIGHTS UPON HEALTHCARE PROVIDERS.

It is difficult to appreciate how far off the rails the Court of Appeals has gone without defining where the rails are. For that, we must consult the language of the statute. Accordingly, in the following discussion, ACIA will first demonstrate the correct analysis of the relevant statute. It will then lead this Court through the sorry saga of this issue in the Court of Appeals since 2005.

The current state of the law is that MCL 500.3112 gives a healthcare provider the right to pursue a direct action against a no-fault insurer. *Elite Health Centers, Inc v State Farm Mutual Automobile Ins Co*, ___ Mich App ___; ___ NW2d ___ (2015) (Court of Appeals No. 322317)[4] (Appendix A), *lv app pending*, Supreme Court No. 152808; *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389; 863 NW2d 54 (2014), *lv den*, 497 Mich 1029 (2015). Understanding why those cases were wrongly decided requires an analysis of the language of the statute, as well as the systemic inertial effect of legally baseless dicta in earlier cases. Accordingly, ACIA will preface its critique of *Wyoming Chiropractic* and *Elite Health* with a discussion of those matters.

[4]ACIA has attached a copy of the slip opinion because no other current version of the opinion is paginated. *Elite Health* was consolidated with *Chiropractors Rehabilitation Group, PC v State Farm*, Court of Appeals No. 320288. The text cites *Elite Health* because the §3112 issue was presented only in that case.

### A. THE RELEVANT STATUTORY LANGUAGE DOES NOT CONVEY ANY RIGHTS ON ANYONE OTHER THAN THE INJURED PERSON AND A DECEDENT'S DEPENDENTS.

The statute on which healthcare providers premise their alleged right to no-fault benefits is MCL 500.3112. However, understanding what that statute addresses requires an appreciation of the nature of the benefits the No-Fault Act provides.

**The General Entitlement Provision**

The provision defining an insurer's obligation to pay benefits in the event of bodily injury or death arising out of the use of a motor vehicle reads in pertinent part as follows:

> "(1) Under personal protection insurance **an insurer is liable to pay benefits for accidental bodily injury arising out of the** ownership, operation, maintenance or **use of a motor vehicle** as a motor vehicle, **subject to the provisions of this chapter**."
>
> * * * *
>
> "(3) **Bodily injury includes death** resulting therefrom and damage to or loss of a person's prosthetic devices in connection with the injury."

MCL 500.3105(1), (3) (emphasis added). Separate provisions define the benefits payable in the event of bodily injury, and those payable in the event of death.

**Allowable Expenses**

The provisions defining the benefits payable in the event of bodily injury not resulting in death read in pertinent part as follows:

> "(a) **Allowable expenses** consisting of all reasonable **charges incurred** for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. . . . "
>
> * * * *

> "(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. . . ."
>
> * * * *
>
> "(c) Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for benefit of himself or herself or of his or her dependent."

MCL 500.3107(1)(a), (b), (c) (emphasis added).

There are two provisions in the Act which specifically reference healthcare providers. One limits the amount that they can charge:

> "**A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person** for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, **may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance**."

MCL 500.3157 (emphasis added).

The other provision requires them to provide a report on the history and condition of the injured person, as well as the treatment rendered. It also requires that they provide access to the injured person's medical records:

> "(2) **A physician, hospital, clinic or other medical institution** providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, **if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection**

> **and copying of its records regarding the history, condition, treatment and dates and costs of treatment**."

MCL 500.3158(2) (emphasis added).

No other provisions in the Act reference healthcare providers.

**Survivor's Loss**

The statute defining benefits payable to dependents of a decedent reads in pertinent part as follows:

> "(1) Except as provided in subsection (2), personal protection insurance **benefits are payable for a survivor's loss which consists of a loss**, after the date on which the deceased died, **of contributions of tangible things of economic value**, not including services, **that dependents of the deceased** at the time of the deceased's death **would have received for support during their dependency** from the deceased if the deceased had not suffered the accidental bodily injury causing death **and expenses**, not exceeding $20.00 per day, **reasonably incurred by those dependents** during their dependency and after the date on which the deceased died **in obtaining ordinary and necessary services in lieu of those that the deceased would have performed** for their benefit if the deceased had not suffered the injury causing death. Except as provided in section (2) **the benefits payable for survivors' loss** in connection with the death of a person **in a single 30-day period shall not exceed $1,000.00** for accidents occurring before October 1, 1978, and shall not exceed $1,475.00 for accidents occurring on or after October 1, 1978, **and is not payable beyond the first three years after the date of the accident**."

MCL 500.3108(1) (emphasis added).

The statutory definition of "dependent" recognizes two categories: those conclusively presumed to be dependents, and those determined to be dependents as a factual matter:

> "(1) The following persons are conclusively presumed to be dependents of a deceased person:
>
> "(a) A wife is dependent on a husband with whom she lives at the time of his death.

"(b) A husband is dependent on a wife with whom he lives at the time of her death.

"(c) A child while under the age of 18 years, or over that age but physically or mentally incapacitated from earning, is dependent on the parent with whom he lives or from whom he receives support regularly at the time of the death of a parent.

"(2) **In all other cases, questions of dependency and the extent of dependency shall be determined in accordance with the facts as they exist at the time of death**."

MCL 500.3110 (1)-(2) (emphasis added).

Note that, unlike allowable expenses, survivor's loss benefits are finite in amount. So with multiple survivor's loss claimants, the benefits must be apportioned. That subject is addressed in §3112.

**Analysis of Section 3112**

The statute on which the providers rely reads in pertinent part as follows:

"Personal protection insurance benefits are payable **to or for the benefit of an injured person or**, in case of his death, **to or for the benefit of his dependents**. **Payment by an insurer** in good faith of personal protection insurance benefits, **to or for the benefit of a person who it believes is entitled to the benefits**, discharges the insurer's liability to the extent of the payments **unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person** to receive the benefits or the proper apportionment among the persons entitled thereto, **the insurer, the claimant or any other interested person may apply to the circuit court** for an appropriate order. **The court may designate the payees and make an equitable apportionment taking into account the relationship of the payees to the injured person and other factors** as the court considers appropriate. **In the absence of a court order** directing otherwise **the insurer may pay**:

"(a) To **the dependents of the injured person**, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.

> "(b) To **the surviving spouse**, the personal protection insurance benefits due any dependent children living with the spouse."

MCL 500.3112 (emphasis added).

The contextual canon upon which ACIA's position rests has been authoritatively articulated as follows:

> "Perhaps **no interpretive fault is more common than the failure to** follow the whole-text canon, which calls on the judicial interpreter to **consider the entire text, in view of its structure and the physical and logical relation of its many parts**. Sir Edward Coke explained the canon in 1628: '[I]t is the most natural and genuine exposition of a statute **to construe one part of the statute by another part of the same statute**, for that best expresseth the meaning of the makers.' Coke added: '**If any section** [of a law] **be intricate**, obscure, **or doubtful, the proper mode of discovering its true meaning is by comparing it with the other sections, and finding out the sense of one clause by the words or obvious intent of the other**.'"

Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* (Thomson/West 2012), p 167 (emphasis added). This Court adheres to that canon:

> "**Individual words and phrases**, while important, **should be read in the context of the entire legislative scheme**. While defining particular words in statutes, **we must consider** both the plain meaning of the critical word or phrase and **its placement and purpose in the statutory scheme**."

*Bush v Shabahang*, 484 Mich 156, 167; 772 NW2d 272 (2009) (emphasis added).

**THE FIRST SENTENCE** of §3112 addresses both allowable expenses and survivor's loss. The references in the first sentence to benefits being payable "to or for the benefit of an injured person" are to allowable expenses. As to allowable expenses, the sentence gives the insurer the option to make payments:

(1) To the injured person, or

(2) To someone else "for the benefit" of the injured person.

The syntax of the sentence leaves no doubt but that **the owner of the right to benefits is the injured person**. It authorizes the insurer to pay them **to him** or **for his benefit**. It does not convey ownership of that right to benefits to anyone else.

That interpretation is conclusively supported by the fact that "allowable expenses" are defined as reasonable charges "**incurred**". MCL 500.3107(1)(a) (emphasis added). In the context of the No-Fault Act, Michigan appellate courts have defined "incurred" as "liable for". *Proudfoot v State Farm Mutual Automobile Ins Co*, 469 Mich 476, 484; 673 NW2d 739 (2003); *Bombalski v ACIA*, 247 Mich App 536, 542; 637 NW2d 251 (2001). The latter case elaborated as follows:

> "This court in *Shanafelt* [*v. Allstate Ins. Co.*, 217 Mich App 625] at 636-636, 552 NW2d 671, addressed the defendant's arguments that certain medical expenses were never incurred as contemplated by subsection 3107(1)(a). **The Court noted that *Random House Webster's College Dictionary* (1995) defined 'incur' as '"to become liable for."'** . . . See also Black's Law Dictionary (7th ed), p 771, which similarly defines incur as **'[t]o suffer or bring on oneself (a liability or expense)**.' The Court rejected the defendant's suggestion that the plaintiff never incurred medical benefits because the plaintiff's health insurer directly paid her medical bills. . . . After quoting the definition of incur found in *Random House Webster's*, the Court reasoned that '**[o]bviously, plaintiff became liable for her medical expenses when she accepted medical treatment**.'"

247 Mich App at 542 (emphasis added).

If a claimant has not incurred an allowable expense, benefits are not payable. *Id*. at 543. **There is no way that a healthcare provider can rationally be held to have become legally liable to pay for a service that it rendered to someone else**. Again, in paying "for the benefit of" the injured person, an insurer is paying in order to discharge the obligation incurred **by the injured person**.

In short, the first sentence of §3112 allows a no-fault insurer to satisfy its §3105 obligation for allowable expenses by paying the money directly to the injured person, or by **discharging the injured person's obligation** by paying the provider "for the benefit of" **the injured person**. Nothing in the first sentence of §3112 can rationally be construed as bestowing a statutory right on the injured person's creditor.

**THE SECOND SENTENCE** of §3112 addresses **only** survivor's loss benefits. Two phrases in the sentence compel that conclusion.

The first is "to or for the benefit of a person **who it believes is entitled to the benefits**". We know from our analysis of the first sentence that allowable expenses are payable "to or for the benefit of an injured person". By hypothesis, the injured person is the **only** person to or for whom allowable expense benefits are payable. Therefore, the phrase under discussion must refer to a claimant of **survivor's loss benefits**.

That point is underscored by the phrase "unless the insurer has been notified in writing of the claim of some other person". Given the option to pay either the injured person (to) or the healthcare provider (for the benefit of the injured person), the phrase cannot tenably be found to refer to allowable expenses, because there can be no "other person" to pay them to. In the context provided by the first sentence and by §3110(2), "some other person" necessarily denotes a person claiming survivor's loss dependency who is not one conclusively presumed to be a dependent pursuant to §3110(1).

**THE THIRD SENTENCE** of §3112 conclusively demonstrates the correctness of that conclusion. Three phrases make that clear.

First, with allowable expenses, there can be no "doubt about the proper person to receive the benefits". They are payable either to the injured person or to the provider, but that is a choice, not a doubt. Such a doubt can arise only as to a §3110(2) survivor's loss claimant.

Second, in the context of allowable expenses, "proper apportionment" is nonsense. An allowable expense is, by definition, a reasonable sum owed by the injured person to the health-care provider. "Apportioning" that sum is a logical impossibility; the injured person owes the entirety of it to the provider. Perforce, the phrase refers to a §3112(2) survivor's loss claim.

A third phrase authorizes "the insurer, the claimant, or any other interested person" to apply to the circuit court for an appropriate order. In the context of allowable expenses, any dispute will be exclusively between the insurer and the claimant (even if the healthcare provider were considered to be a claimant). There can be no "other interested person" with regard to allowable expenses. Again, the phrase makes sense only in the context of a §3110(2) claim.[5]

**THE FOURTH SENTENCE** of §3112 should remove any lingering doubt as to the accuracy of the foregoing analysis.

First, it authorizes the court to make an "equitable apportionment" of the benefit. Such an apportionment necessarily assumes a limited benefit -- such as survivor's loss, MCL 500.3108(1). Allowable expenses are **not** limited, MCL 500.3107(1), and therefore do not need to be apportioned.

[5]In the context of §3110(2), the claimant can be any non-3110(1) person receiving support from the decedent, including a child not receiving "regular" support. An "interested person" could be a person legally responsible for the claimant, or having some other fiduciary or custodial relationship to him or her.

Second, in making the apportionment, the circuit court may take into account "the relationship of the payees to the injured person".[6] In the context of a provider's bill for services rendered, its "relationship" to the injured person can have no possible relevance to its entitlement to be paid. If the insured person qualifies for benefits, the insurer is liable to pay "all reasonable charges incurred" by the injured person. MCL 500.3107(1)(a). Again, the phrase makes sense only in the context of §3110(2) survivor's loss.

In sum:

(1) In terms, the first sentence of §3112 addresses both allowable expenses and survivor's loss.

(2) The second sentence provides "a 'safe'" method of paying **survivor's loss benefits**. *Miller v State Farm Mutual Automobile Ins Co*, 410 Mich 538, 546; 302 NW2d 537 (1981).

(3) The third sentence prescribes the remedy for resolving any disputes as to entitlement to or apportionment of **survivor's loss benefits**. *Poling v Secretary of State*, 142 Mich App 54, 59; 369 NW2d 261 (1985).

(4) The fourth sentence provides for the "equitable apportionment" of **survivor's loss benefits**, as well as the factors to be considered.

(5) The fifth sentence, on its face, pertains only to **survivor's loss benefits**.

There is nothing in the language of §3112 that invests a healthcare provider with a **right** to demand allowable expenses directly from a no-fault insurer.

[6]Section 3112 refers to the decedent as "an injured person".

### B. THE CASES PRIOR TO 2014 WHICH RECOGNIZED A PROVIDER'S SUBSTANTIVE RIGHT AGAINST A NO-FAULT INSURER WERE WRONGLY DECIDED AND NOT CONTROLLING.

Having demonstrated the correct interpretation of §3112, ACIA will set forth the decisional background for the *Wyoming Chiropractic* and *Elite Health* cases.

The case most frequently cited by healthcare providers was *Lakeland Neurocare Centers v State Farm*, 250 Mich App 35; 645 NW2d 59 (2002). However, the issue of a provider's right of direct action was **not decided** in that case, because it was **conceded**:

> "In this case, **defendant did not dispute that plaintiff had the legal right to commence this action** for payment of medical services rendered to defendant's insured."

*Id*. at 37 (emphasis added). A case is not controlling precedent as to an issue not actually considered. *Sizemore v Smock*, 430 Mich 283, 291 n 15; 422 NW2d 666 (1988); *In re Fitch Drain*, 346 Mich 81, 90; 77 NW2d 450 (1956).

Also regularly cited by providers was *Regents of University of Michigan v State Farm*, 250 Mich App 719; 650 NW2d 129 (2002). Again, the question of the provider's right to sue a no-fault insurer directly was not litigated. Rather, the language concerning "direct claims for personal protection insurance benefits" appears in a passage explaining why the tolling provision of MCL 600.5821(4) applied to negate the one-year-back rule of MCL 500.3145(1). *Id*. at 733.[7] A point assumed without consideration is, of course, not decided, *Chapman v Buder*, 14 Mich App 13, 20; 165 NW2d 436 (1968), and is therefore not precedentially binding.

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[7]That holding was overruled in *Liptow v State Farm*, 272 Mich App 544; 726 NW2d 442 (2006), *overruled by Regents of University of Michigan v Titan Ins Co*, 487 Mich 289; 791 NW2d 897 (2010), *but reaffirmed by Joseph v ACIA*, 491 Mich 200; 815 NW2d 412 (2012).

Moreover, neither of the cases cited by the *Regents* panel involved a right to a direct action for benefits. In *LaMothe v ACIA*, 214 Mich App 577, 585-86; 543 NW2d 42 (1995), the no-fault insurer refused to pay the entirety of the provider's bill on the ground that it was unreasonably high. The insurer agreed to defend and to hold the insured harmless against any action by the provider. *Id*. at 583-84. Accordingly, the insured's suit against the insurer for the unpaid excess was dismissed.

*Munson Medical Center v ACIA*, 218 Mich App 375; 554 NW2d 49 (1996), was another case in which, consistent with *LaMothe*, the no-fault insurer agreed to be sued by the provider over the reasonableness of the provider's charges.

Another decision expressing a belief that a provider has a direct cause of action against a no-fault insurer was *Michigan Head & Spine Institute, PC v State Farm*, 299 Mich App 442, 448 n 1; 830 NW2d 781 (2013), *citing Lakeland Neurocare Centers v State Farm, supra*. However, the only issue in that case was whether an insured's release barred a provider's claim for services rendered after the release was executed. 299 Mich App at 448. Therefore, the passage in question was dictum.

Another case which parroted *Lakeland Neurocare* was *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31, *lv gt'd*, 497 Mich 866; 853 NW2d 331 (2014), *app dis'd*, ___ Mich ___; 858 NW2d 462 (2015). In the course of explaining that a provider's right to recover is totally dependent on the right of the insured to recover, the *Moody* panel mentioned in passing that providers may bring an independent cause of action against a no-fault insurer. *Id*. at 440. Again, the passage was dictum, the issue having been neither argued nor substantively addressed in the opinion.

In sum, the "common wisdom" that a provider has a right to sue a no-fault insurer to recover benefits was the product of a line of cases which never analyzed the language of §3112. They simply concluded that it conveyed such a right. The inertial effect of those cases is evident in *Wyoming Chiropractic* and *Elite Health*.

### C. *WYOMING CHIROPRRACTIC* AND *ELITE HEALTH* DID NOT PROPERLY CONSTRUE MCL 500.3112.

Having provided the necessary statutory and decisional background, ACIA will demonstrate that both *Wyoming Chiropractic* and *Elite Health* were wrongly decided.

*Wyoming Chiropractic* suffers from two major flaws. The first is that it badly misread and misapplied the case law on which it relied.

The *Wyoming Chiropractic* panel erroneously implied that in *Munson, supra*, at 281, the Court of Appeals noted that the provider had a "right to be paid for the injured's no-fault medical expenses" under MCL 500.3112, which the *Wyoming Chiropractic* opinion had just quoted. 308 Mich App at 393. In fact, the full quotation, from which *Wyoming Chiropractic* took a snippet, reads as follows:

> "ACIA's obligation to pay and Munson's right to be paid for the injured's no-fault medical expenses arise pursuant to M.C.L. §§500.3105, 500.3107, and 500.3157 . . . ."

218 Mich App at 381.

Section 3112 was not even cited. Moreover, as noted above in *Munson*, ACIA **agreed** to litigate directly against the provider, because the only issue was the amount owed.[8] *See LaMothe, supra*, at 580-81; *McGill v ACIA*, 207 Mich App 402, 404; 526 NW2d 12 (1994).

[8]The law firm of the undersigned attorney litigated the *Munson* appeal.

*Munson* cannot possibly be considered support for a provider's right to sue a no-fault insurer directly.

Next, *Wyoming Chiropractic* posited that in *Lakeland Neurocare, supra at* 38-39:

> "This Court analyzed the plain language of MCL 500.3112 and determined that the plaintiff was entitled to prompt payment because the plaintiff brought a claim for PIP benefits 'for the benefit of' the insured when the plaintiff submitted a claim for PIP to the defendant."

308 Mich App at 394.

This is what *Lakeland Neurocare* actually said:

> "Further, contrary to the trial court's conclusion, the fact that plaintiff was not the injured person is not dispositive. MCL 500.3112 specifically contemplates the payment of benefits to someone other than the injured person as reflected by its inclusion of the phrase 'benefits are payable to or for the benefit of an injured person' and by its discharge of an insurer's liability upon payment made in good faith to a payee 'who it believes is entitled to the benefits. . . .' As a result, it is common practice for insurers to directly reimburse healthcare providers for services rendered to their insureds. . . . Moreover, **M.C.L. §500.3142 does not limit the right to seek penalty interest solely to the injured person and if the Legislature intended to limit the penalty provision, it could have done so**."

250 Mich App at 39-40 (emphasis added).

The point was that as a litigant, the provider was entitled to no-fault penalty interest, not that the provider had the right to commence an action -- which "the defendant did not dispute" in that case. *Id.* at 38.

Next, *Wyoming Chiropractic* said that in *Regents of the University of Michigan v State Farm*, 250 Mich App 719, 733; 650 NW2d 129 (2002), *overruled in Liptow v State Farm*, 272 Mich App 544, 549; 726 NW2d 442 (2006)[9], the Court clarified that "'[a]lthough plaintiffs may

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[9] *Liptow* itself was overruled by *Regents of University of Michigan v Titan Ins Co*, 487 Mich 289; 791 NW2d 897 (2010), but was reaffirmed by *Joseph v ACIA*, 491 Mich 200, 222 & n 49; 815 NW2d 412 (2012).

have derivative claims, they also have direct claims for personal protection insurance benefits'". 308 Mich App at 395.

However, *Regents* never cited §3112 as the basis for its conclusion. Indeed, it did not even mention §3112. It simply cited *Munson* and *LaMothe*, in which the insurers agreed to litigate directly against the provider.

Next, the *Wyoming Chiropractic* panel spent a paragraph discussing the majority opinion in *Borgess Medical Ctr v Resto*, 273 Mich App 558; 730 NW2d 738 (2007), *vacated and concurrence adopted*, 482 Mich 946; 754 NW2d 321 (2008), **concluding that it could not rely on it**. 308 Mich App at 395-96.

Finally, the *Wyoming Chiropractic* panel cited *Michigan Head & Spine Institute, Inc v State Farm, supra,* which merely cited *Lakeland Neurocare*. *Id.* at 396. Again, no statutory analysis was undertaken.

In short, none of the case law on which the *Wyoming Chiropractic* panel relied actually provided tenable support for the conclusion that §3112 created a direct cause of action for a healthcare provider.

The second flaw in *Wyoming Chiropractic* is that it asserted that recognizing a provider's right to sue is good public policy. 308 Mich App at 401. That is nothing short of absurd. Inviting **hundreds and hundreds** of lawsuits -- **in addition to the insureds'** -- hardly serves the No-Fault Act's underlying purpose of reducing litigation, *e.g., Lewis v DAIIE*, 426 Mich 93, 102; 393 NW2d 167 (1986), *overruled on other gds, Devillers v ACIA*, 473 Mich 562; 702 NW2d 539 (2005). Moreover, multiplying the transactional costs involved in defending hundreds of additional lawsuits certainly places upward pressure on premiums. This Court has recognized

that keeping premiums affordable is an issue of constitutional dimension. *Shavers v Kelley*, 402 Mich 554, 599; 267 NW2d 72 (1978). The *Wyoming Chiropractic* holding is blatantly inimical to that purpose.

*Elite Health* suffers from many of the same flaws as *Wyoming Chiropractic*. It begins its discussion by rotely citing *Munson, Lakeland Neurocare,* and the other cases discussed in the previous sub-issue of this brief. (Appendix A, slip op at 5-6 & n 3).

To that list, *Elite Health* adds *Wyoming Chiropractic* and also the instant case, in which the panel averred that the second sentence of §3112 evinced a legislative intent that a healthcare provider has a right to benefits independent of the right of the injured person. (Appendix B, slip op at 2). As was explained above, the second sentence of §3112 addresses only survivor's loss benefits. (See p 14, *supra*). It provides a safe method of paying such benefits unless an "other person" has claimed to be entitled to a portion of such benefits.

In contrast, the *Elite Health* opinion itself relies on the first sentence of §3112 as the source of the provider's purported right. It reaches that result by the following route:

> "MCL 500.3112 states, in pertinent part, that '[p]ersonal protection insurance benefits are payable to *or for the benefit of* an injured person or, in the case of his death, to or for the benefit of his dependents.' MCL 500.3112 (emphasis added). 'The word "or" is a disjunctive term indicating a choice between alternatives.' . . . Accordingly, the plain language of the statute reveals a legislative intent to allow either the injured person *or* a party that provided benefits to an injured person to **recover** the payment of benefits from an insurer; the injured person is not the only party who has this right."

(Appendix A, slip op at 5-6) (last emphasis added; other emphasis in original).

As was explained above (p 12-14, *supra*), that sentence allows an insurer to pay either the injured person or the provider. *Elite Health* transmutes that choice into an entitlement by simply

declaring that the phrase allows a provider to "recover" the benefits. In terms, however, the first sentence of §3112 does no such thing. It creates the possibility for the provider to receive the payment of benefits directly. However, that does not logically translate into a right of the provider to insist that it recover such benefits from the insurer. A provider who has not been paid has recourse only against the injured person, *Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011), who may then seek payment from the no-fault insurer.

## CONCLUSION

Not a single Court of Appeals case has ever attempted to construe §3112 in the **context** of "**its placement and purpose in the statutory scheme**", *Bush*, *supra*. Instead, we have a series of cases with conclusory dicta and holdings based on reading snippets of §3112, with not even a whisper of what the Legislature was addressing when it enacted it.

This Court should renounce that approach, undertake an informed analysis of §3112, and hold that it bestows no rights on a healthcare provider to recover no-fault benefits.

## II. EVEN IF HEALTHCARE PROVIDERS HAVE A PROCEDURAL RIGHT TO SUE, THEIR SUBSTANTIVE RIGHTS ARE TOTALLY SUBSERVIENT TO THOSE OF THE INJURED PERSON, WHO MAY WAIVE OR SETTLE THEM AS HE SEES FIT.

At the outset, ACIA acknowledges that its analysis of this issue cannot be entirely satisfactory. That is a function of the incompatibility of recognizing a procedural right to litigate without an independent substantive right to recover.

For example, the Court Rules require that an injured person suing his no-fault insurer must join all of his claims for all of his allowable expenses in that suit. MCR 2.203(A). A judgment in that suit will be res judicata as to any provider's claim that could have been litigated in that suit. *E.g., TBCI, PC v State Farm Mutual Automobile Ins Co,* 289 Mich App 39, 43-44; 795 NW2d 229 (2010).

A necessary corollary of the foregoing is that the injured person may waive or settle the provider's claim against the no-fault insurer. *Miller v Citizens Ins Co, supra*; *Moody v Home Owners Ins Co, supra*; *Michigan Head & Spine Institute, PC v State Farm, supra* at 447; *Nicholson v Citizens Ins Co,* unpublished per curiam opinion of the Court of Appeals, rel'd 3/6/12 (No. 300592) (Appendix C), p 3.

It is that line of cases that the Court of Appeals ignored in the instant case. As noted above, the Court of Appeals' holding necessarily assumes that Plaintiff had a substantive right to recover independent of the insured's, i.e., "the claim of some other person".

The *Covenant* panel can be forgiven for slipping in to that error. After all, the Court of Appeals has consistently held that a provider a right to sue on its on behalf. It is counter-intuitive

to conclude that that independent right to sue can be erased by the injured person. If that is possible, then how "independent" is that right?

All of which underscores the point made in the Introduction to this brief. Once we go "down the rabbit hole" by concluding that §3112 confers any right on a healthcare provider, we should not be surprised at anomalous results. The only true solution is to correct that basic misapprehension. (See Issue I., *supra*).

Failing that, however, this Court should at least afford no-fault insurers a reasonable manner in which to attempt to manage the avalanche of provider suits created by *Lakeland Neurocare* and its progeny. That would require a reaffirmation of the procedural right/substantive right dichotomy created by the Court of Appeals. This Court should hold, at a minimum, that the insured's settlement of its claim against STATE FARM extinguished Plaintiff's right to recover.

## RELIEF

Amicus Curiae, AUTO CLUB INSURANCE ASSOCIATION ("ACIA"), prays this Honorable Court to grant leave to appeal in the instant case ACIA further prays that, after full briefing and argument, this Court hold that the No-Fault Act confers no right of any kind on a healthcare provider. In the alternative, ACIA prays that this Court hold that a settlement by the injured person with his no-fault insurer binds any healthcare provider who has provided him treatment.

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